GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 6, 2026

James Boyd
Crisis Center Inc - DBA Listening Ear
PO Box 800
Mt Pleasant, MI 48804-0800

RE: License #: AS540420160
Investigation #: 2026A1029058
Pineport AFC

Dear Mr. Boyd:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the licensee designee and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (231) 922-5309.

Sincerely,

Jennifer Browning

Jennifer Browning, Licensing Consultant
Bureau of Community and Health Systems
browningj1@michigan.gov - 989-444-9614

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AS540420160
Investigation #:	2026A1029058
Complaint Receipt Date:	07/24/2026
Investigation Initiation Date:	07/24/2026
Report Due Date:	09/22/2026
Licensee Name:	Crisis Center Inc - DBA Listening Ear
Licensee Address:	107 East Illinois, Mt Pleasant, MI 48858
Licensee Telephone #:	(989) 773-6904
Administrator:	James Boyd
Licensee Designee:	James Boyd
Name of Facility:	Pineport AFC
Facility Address:	915 N Dekraft, Big Rapids, MI 49307
Facility Telephone #:	(231) 796-3993
Original Issuance Date:	02/24/2026
License Status:	TEMPORARY
Effective Date:	02/24/2026
Expiration Date:	08/23/2026
Capacity:	6
Program Type:	PHYSICALLY HANDICAPPED DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Resident A was administered the wrong dose of Trazodone for 22 days.	Yes

III. METHODOLOGY

07/24/2026	Special Investigation Intake 2026A1029058
07/24/2026	Inspection Completed On-site - Special Investigation Initiated - Face to Face with Regional manager, Dawn Vallad, direct care staff members Becky Hayner, Holly Hoffman at Pineport AFC
07/28/2026	Contact - Telephone call made to licensee designee to licensee designee Jim Boyd, email to ORR Keegan Sarker
08/06/2026	Contact – Telephone call to direct care staff member Cherry Dennis, LTC Pharmacy Manager Erin West, and ORR Ms. Sarker
08/06/2026	APS referral made to Centralized Intake
08/06/2026	Exit conference with licensee designee Jim Boyd

ALLEGATION: Resident A was administered the wrong dose of Trazodone for 22 days.

INVESTIGATION:

07/24/2026 I entered a complaint after completing a renewal on-site inspection, during which Dawn Vallad reported the medication error to me. Ms. Vallad stated the error occurred because the medication instructions were incorrectly transcribed on the *Medication Administration Record* (MAR) and the pharmacy also packaged the medication incorrectly, contributing to the error. Ms. Vallad reported the error began on 07/01/2026 and continued for 22 days until 07/23/2026. She stated that direct care staff member Cherry Dennis brought the concern to her attention after noticing the medication packaging appeared incorrect. Ms. Vallad stated she also reported the issue to ORR investigator Keegan Sarker upon discovering the error, and ORR is also investigating the matter.

During the on-site investigation, I reviewed all of Resident A’s medications to ensure they were present in the facility. I reviewed the following documents related to this incident:

- Resident A's MAR for July 2026, which listed Trazodone 50 mg with instructions from 07/01/2026–07/22/2026 to administer 1.5 tablets by mouth at bedtime. A notation stated "see next page," and the medication was discontinued for the remainder of the month once the error was identified. Updated instructions beginning 07/23/2026 stated: Trazodone 50 mg – take one-half tablet by mouth at bedtime.

- Resident A's bubble pack for Trazodone showed 1.5 tablets in each blister cavity, with printed instructions to "take one-half tablet by mouth every night at bedtime," despite the 1.5-tablet packaging.

- The physician's order for Trazodone, effective 04/03/2026, directed administration of one-half tablet by mouth nightly for 90 days.

On 07/24/2026, I interviewed direct care staff member whose role is home manager, Rebecca Hayner. Ms. Hayner stated the MAR instructions were written based on the bubble pack but were transcribed incorrectly, resulting in "one and one-half tablets" being entered instead of "one-half tablet as directed on the bubble pack." Ms. Hayner stated she likely thought this was the case because there were 1.5 tablets in each blister cavity which contributed to the medication error.

I reviewed the *AFC Incident / Accident Report* written on 07/23/2026 by Ms. Vallad:

Explain What Happened

A staff member reported feeling confused about the medication instructions for [Resident A] was receiving. The assistant looked at medication and saw her 50 mg Trazodone. The order stated to give 0.5 tablets by mouth at bedtime daily for 90 days. However, the pharmacy's bubble pack contained one and a half tablets in each dose, and the medication administration sheet also indicated giving 1.5 tablets at bedtime.

Action Taken by Staff / Treatment Given

Staff contacted the pharmacy for clarification. The pharmacy technician asked if it was a whole month and asked if she had any symptoms from the dose and she told her no.

Corrective Measures Taken to Remedy and/or Prevent Recurrence

Staff verified the correct dose with the pharmacy to ensure accuracy moving forward. The medication concern was reported to the appropriate individuals, and communication steps were taken to prevent future dosing discrepancies. Pharmacy technician said they were to only give 1/2 tab and dispose of the whole pack and they would send a new cartridge for her tomorrow. Technician also stated they would call Harmony Care. At 5:40 PM Pharmacy or Doctor didn't call back so she called LTC Pharmacy. This error means that she received 75 mg tablet daily instead of her prescribed dosage of 25 mg for 22 days.

Ms. Vallad stated she has implemented the following plan of correction after this incident:

1. She will actively monitor direct care staff members to ensure they are using the medication order book when administering medications.
2. Only three designated individuals will check in medications and complete the MAR when new medications arrive from the pharmacy.
3. All direct care staff members will repeat medication administration training.

On 07/28/2026, I interviewed licensee designee Jim Boyd. Mr. Boyd stated he was aware of the medication error and found it frustrating that the pharmacy packaged the medication incorrectly; however, he also stated direct care staff members should have identified the discrepancy when entering the information into the MAR at the beginning of the month. Mr. Boyd reported Resident A did not experience any side effects.

On 08/06/2026, I interviewed direct care staff member Cherry Dennis. Ms. Dennis was the direct care staff member who first noticed the instructions and MAR did not match. She stated that during medication administration she observed the dose appeared incorrect, as it had been one-half tablet the previous month and was listed as 1.5 tablets for July, which she did not recall being changed. Ms. Dennis reported she brought the concern to management, and upon review with Ms. Hoffman, they determined it was a medication error. Ms. Dennis stated the medication administration procedure is to follow the medication book and the label on the medications. She reported no concerning side effects, although she observed the resident appeared to sleep more on a few nights. Ms. Dennis stated she believes Ms. Hoffman contacted the pharmacy. She reported the pharmacy confirmed the medication had been packaged incorrectly and instructed the facility to dispose of the incorrect packs and await replacement.

On 08/06/2026, I interviewed Long Term Care (LTC) Pharmacy Manager Erin West. Ms. West stated the correct instruction was one-half tablet at bedtime, but the pharmacy mistakenly packaged 1.5 tablets per dose beginning 07/01/2026. She stated they were not notified until 07/23/2026. Once informed, she contacted the resident's physician's office and sent corrected packaging for the remaining eight days of July. Ms. West acknowledged the packaging error and stated the pharmacy completes typed, color-coded MAR sheets for homes, which are sent with the medications so the MARs should not be handwritten except for short-term medications such as antibiotics.

On 08/06/2026, I interviewed ORR Investigator Ms. Sarker. She was informed of the information provided by Ms. West, including that the facility receives color-coded MAR sheets and does not need to rewrite them. Ms. Sarker stated her investigation is not yet complete but she will likely cite due to the number of individuals who missed the error over this time period.

On 08/06/2026, I completed the exit conference with licensee designee Jim Boyd. Mr. Boyd stated only three individuals will be responsible for checking in medications. He stated staff must ensure medications are not missing and that medication instructions match during the check-in process. Mr. Boyd stated he will address these requirements in the corrective action plan and also make sure they are reviewing the physicians orders for each medication to prevent this issue from reoccurring in the future.

APPLICABLE RULE	
R 400.675	**Resident medications.**
	(1) Medication must be given, taken, or applied as prescribed, ordered, or directed by an appropriately licensed health care professional.
ANALYSIS:	Resident A received the incorrect Trazodone dose for 22 days because the physician-ordered instruction of one-half tablet at bedtime was not followed, resulting in 1.5 tablets being administered nightly instead of one .5 tablet. Although the pharmacy contributed by incorrectly packaging the medication, interviews with Ms. Vallad, Ms. Dennis, Ms. Hoffman, pharmacy manager Ms. West, licensee designee Mr. Boyd, and ORR investigator Ms. Sarker demonstrate that multiple layers of oversight including MAR transcription, medication check-in procedures, and daily administration checks failed to identify the discrepancy for 22 days causing Resident A to receive the incorrect dosage.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Upon receipt of an approved corrective action plan, I recommend no change in the license status.

Jennifer Browning _____08/06/2026_____

Jennifer Browning
Licensing Consultant
Date

Approved By:

Dawn Timm 08/06/2026

_____

Dawn N. Timm
Area Manager
Date